Guaranteed Issue Shield Spectrum PPO Plan 1500
Comparative Benefit Matrix (AB 1401)
Effective - January 1, 2009

Plan Name:	**Plan Contact Phone Number:**
Blue Shield of California Guaranteed Issue Shield Spectrum PPO Plan 1500	IFP Customer Service 1-800-431-2809

Coverage summary (2) (***3)**

Eligibility requirements	Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may be entitled to apply for certain of Blue Shield's individual health plans on a guaranteed issue basis (which means that you will not be rejected for underwriting reasons if you meet the other eligibility requirements, you live or work in Blue Shield's service area and you agree to pay all required dues). Not all Blue Shield individual plans are available on a guaranteed issue basis under HIPAA. To be eligible for a guaranteed issue plan, you must meet the following conditions: a. You have had a total of at least 18 months of health care coverage (including COBRA or CalCOBRA) without more than a 63-day break in coverage, b. Your most recent coverage was through an employer-sponsored health plan (COBRA and CalCOBRA are considered employer-sponsored coverage), c. You have elected and exhausted all COBRA and/or CalCOBRA coverage that is available to you, d. You are not currently eligible for coverage under a group health plan, and e. Your most recent coverage was not terminated because of non-payment of dues or fraud. You must submit an application to Blue Shield for guaranteed issue coverage within 63 days of the date of termination from your group plan coverage. (*1) Subscribers must be residents of California. Upon change of residence to another jurisdiction, coverage under this agreement will end. Coverage may be transferred to a Blue Cross or Blue Shield Plan for that jurisdiction, if any.
The premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside	Premiums charged by plans vary by region and age of subscribers. See "Premium Rate" tab for this plan.

When and under what circumstances benefits cease	Benefits cease: a. 30 days written notice from the subscriber; b. Material information that is false or misrepresented information provided on the enrollment application or given to the Plan; c. Permitting use of your Subscriber identification card by someone other than yourself or your Dependents to obtain Services; d. Obtaining or attempting to Obtain Services under this Agreement by means of false, materially misleading, or fraudulent information, acts or omissions; e. Disruptive behavior or threatening the life or well-being of Blue Shield of California personnel and providers of Services. Benefits terminate: f. For subscriber's dependent child on the 32nd day following their effective date unless a change request form has been filed with the plan; g. For dependents at age 19, if not full time student; h. At age 23 if full time student; This does not apply to a child of a legal guardian unless a court has specifically ordered that the guardianship continue beyond the attainment of age 19. i. Moving out of California; j. For a dependent spouse upon a final decree of divorce, annulment, or dissolution of marriage from subscriber; or k. Failure to pay dues
The terms under which coverage may be renewed	Any change in dues or benefits are effective after 30 days notice from the date of mailing to the Subscriber's address of record with plan. Blue Shield of California shall renew this Agreement, except under the following conditions: 1. Non-payment of dues; 2. Fraud, misrepresentation, or omission; 3. Termination of plan type by Blue Shield of California; 4. Subscriber moves out of the service area or is no longer a resident of California; 5. If a bona fide association arranged for the Subscriber's coverage under this Agreement, when that Subscriber's membership in the association ceases.
Other coverage that may be available if benefits under the described benefit package cease	If a Subscriber moves out of state to an area served by another Blue Cross or Blue Shield ("BC/BS") plan and notifies plan of new address, the Subscriber's coverage may be transferred to the plan serving his new address. The new plan must offer the Subscriber at least its conversion policy. Whether or not the change in residence is to an area outside of California and BC/BS plan for that jurisdiction is not available, coverage under this plan will be terminated.
Lifetime and annual maximums	<u>Lifetime maximum:</u> $6,000,000 determined by aggregating all benefits provided for or on behalf of any Person, either as a Subscriber or a Dependent. <u>Calendar-year Copayment Maximum:</u> Preferred Providers: $4,500 per Individual or $9,000 per Family Non-Preferred Providers: $9,000 per Individual or $18,000 per Family
Deductibles	Calendar-year medical plan deductible of $1,500/ Individual or $3,000 /Family. Family is defined as two or more persons.

Benefits Summary (**2) & (***3)		Co-payments	Limitation
Professional Services	Physician office visits, including, but not limited to preventive care, immunizations, screenings and diagnostic visits.	Physician and Specialist Office Visits: ➢ Preferred Providers: $40 ➢ Non-Preferred Providers: 50%	Preventive, Annual Gynecological, and Well Baby Visits by Non-Preferred Providers are not covered.
		Internet Based Consultations: ➢ Preferred Providers: $10 ➢ Non-Preferred Providers Not Covered ➢	Internet based consultations are available to Subscribers only through Preferred Physicians who are internet ready.
		Skilled Nursing Facility, or Visits to the Person's home: ➢ Preferred Providers: 30% ➢ Non-Preferred Providers: 50%	
		Physician Services While Hospitalized ➢ See "Hospitalization Services"	
Outpatient Services	Outpatient services, including, but not limited to surgery and treatment, and diagnostic procedures.	Outpatient or Out-of-Hospital X-ray and Laboratory ➢ Preferred Providers: 30% ➢ Non-Preferred Providers: 50%*	*Charges assessed per provider, per date of service
		Outpatient Surgery in an Ambulatory Surgery Center (ASC): ➢ Preferred Providers: 30% ➢ Non-Preferred Providers: 50% of up to $300, plus all charges over $300/ visit*	* Blue Shield of California payment not to exceed $150 per day.
		Surgery in Outpatient Department of a Hospital: ➢ Preferred Providers: $250/admit + 30% ➢ Non-Preferred Providers: 50% of up to $500, plus all charges over $500/day*	* Blue Shield of California payment not to exceed $250 per day.
		Hospital Outpatient Services ➢ Preferred Providers: $250/admit + 30% ➢ Non-Preferred Providers: 50% of up to $500, plus all charges over $500/day*	* Blue Shield of California payment not to exceed $250 per day.

Benefits Summary (**2) & (***3)		Co-payments	Limitation
		Prenatal and Postnatal Care; Outpatient Rehabilitation services provided in the Office of a physician or Office of physical, occupational, or respiratory therapist: ➢ Preferred Providers: 30% ➢ Non-Preferred Providers: 50%	
		Rehabilitation Services provided in a Hospital Outpatient Department ➢ Preferred Providers: 30% ➢ Non-Preferred Providers: 50% of up to $500/day + charges above $500/day*	Does not accrue to copayment maximum * Blue Shield of California payment not to exceed $250 per day.
		Family Planning Consultations, Elective Abortions, Tubal Ligations & Vasectomy: ➢ Preferred Providers: 30% ➢ Non-Preferred Providers: Not Covered	
Hospitalization Services	Inpatient and outpatient services, including, but not limited to room board and supplies.	➢ Preferred Providers: $250/admit* + 30% ➢ Non-Preferred Providers: 50% of up to $500, plus all charges over $500/day*	* Blue Shield of California payment not to exceed $250 per day.
	Physician Inpatient Services	➢ Preferred Providers: 30% ➢ Non-Preferred Providers: 50%	
Emergency Health Coverage	Emergency room services, including physician services, at preferred and non-preferred facilities for medically necessary emergency services.	➢ Hospital Emergency Room: $100/visit* + 30%	*$100 waived if admitted
		Physician Services received during ER visit: ➢ 30%	
Ambulance Services	Emergency ambulance transport.	➢ 30%	When medically necessary. Includes both surface and air services.

Benefits Summary (**2) & (***3)		Co-payments	Limitation
Prescription Drug Benefits	Medically necessary drugs prescribed by a physician.	➢ $10 Formulary Generic Drugs; ➢ $20 for Mail-Service Formulary Generic Drugs; ➢ $35 for Formulary Brand Drugs; ➢ $70 for Mail-Service Formulary Brand Drugs ➢ $50 or 50% of Blue Shield's contracted rate, whichever is greater, for Non-Formulary Brand Drugs; ➢ $100 or 50% of Blue Shield's contracted rate, whichever is greater, for Mail-Service Non Formulary Brand Drugs ➢ 30% negotiated Blue Shield of California contracted rate for Home Self-Administered Injectables	➢ Drugs received from Non-Participating Pharmacies, except for emergency coverage, drugs for emergency contraception, and drugs obtained outside of California which are related to an urgently needed service and for which a Participating Pharmacy was not reasonably accessible, are not covered. ➢ Calendar-Year Brand Name Drug Deductible: $500 Brand Name Deductible Per Person must be met before Brand and Non-Formulary drug coverage begins. ➢ Injectable Drugs for the treatment of infertility and contraceptive implants are excluded. ➢ Outpatient Prescription Drugs are limited to a quantity not to exceed a 30-day supply. ➢ Mail Service Prescription Drugs are limited to a quantity not to exceed a 60-day supply. ➢ Benefits are provided for Home Self-Administered Injectables (excluding fertility injectables) only when obtained from a pharmacy designated in a specialty network, except in the case of an emergency.
Durable Medical Equipment	Durable medical equipment, including, but not limited to, oxygen, parental and enteral nutrition, colostomy supplies, corrective prosthetics and aids, and diabetic supplies.	➢ Preferred Providers: 30%* ➢ Non-Preferred Providers: Not covered	No benefits are provided for wigs, home testing devices, environmental control equipment, self-help/educational devices or any type of speech or language assistance devices, air-conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, or any other equipment not primarily medical in nature. * Blue Shield of California payment not to exceed $2000/person/CY.
Mental Health Services	Inpatient and outpatient mental health services, including, but not limited to, mental health parity services for serious mental disorders and severe emotional disturbances for children.	<u>Hospital Facility Services and Partial Hospitalization Services (Inpatient Services):</u> ➢ Participating Hospital: $250/admit + 30% ➢ Non Participating Hospital: 50% of up to $500, plus all charges over $500/day*	* Blue Shield of California payment not to exceed $250 per day.
		<u>Inpatient Professional (Physician) Services:</u> ➢ Participating Provider: 30% ➢ Non-Participating Provider: 50%	

Benefits Summary (**2) & (***3)		Co-payments	Limitation
		Outpatient Facility and Office Care for Severe Mental Illness or Serious Emotional Disturbances of a Child: ➢ Participating Provider: $40/visit ➢ Non-Participating Provider: 50%	No visit maximum.
		Outpatient Facility Care and Office Visits for other than Severe Mental Illness or Serious Emotional Disturbances of a Child, Initial Visit, and Substance Abuse care: ➢ Participating Provider: 30%/ visit ➢ Non Participating Provider: Not Covered	➢ Except for the initial visit which will be paid as if the condition was a Severe Mental Illness or Serious Emotional Disturbance of a Child. ➢ Combined benefit maximum of 20 visits for each Person per Calendar Year, including Chemical Dependence Services.
Residential Treatment	Transitional residential recovery services.	Not Covered	
Chemical Dependence Services	Substance abuse treatment or rehabilitation.	Outpatient Facility and Office Care ➢ Participating Provider: 30%/ visit ➢ Non-Participating Provider: Not Covered	Combined benefit maximum of 20 visits for each Person per Calendar Year, including Outpatient Facility Care and Office Visits for other than Severe Mental Illness or Serious Emotional Disturbances of a Child, Initial Visit, and Substance Abuse care.

Home Health Services	Home health care services. (****4)	➢ Participating Provider: 30% of the Allowable Amount
		➢ Non Participating Provider
		  ➢ When Prior Authorized: 30%
		  ➢ If Not Prior Authorized: Not Covered
			90 visit maximum per insured per calendar year.

Custodial Care and skilled nursing facilities	Skilled Nursing care and skilled nursing facilities services.	Provided by a Hospital Skilled Nursing Facility Unit: ➢ Preferred: 30% ➢ Non-Preferred: 50% Provided by a Freestanding Skilled Nursing Facility: ➢ 30% and all charges above the Allowable Amount Custodial Care: Not Covered	Calendar-year maximum of 100 days.
Chiropractic Services		➢ Preferred Providers: 50% of the allowable amount up to a maximum payment of $25 ➢ Non-Preferred Providers: Not Covered	12 visit maximum per calendar year

a) (*1) If you elect Individual Conversion Coverage, Continuation of Group Coverage After COBRA and/or CalCOBRA, or other individual plan coverage, you will waive your right to Guaranteed Issue coverage
(**2) This is a benefit summary. Please consult the individual plan's Evidence of Coverage for more detailed information on benefits under the plan, including any related exclusions not contained in this benefit summary.
(***3) Percentage co-payments represent a percentage of actual cost. For participating providers paid on a fee for service basis, the actual cost is the rate negotiated with the provider (referred to as the "negotiated rate" or the "allowable amount"). Percentage copayments for non-emergency services provided by non-participating providers are calculated based on the amount the plan would pay for a participating provider, or billed charges whichever is less, and enrollees are also responsible for any excess amount.

(****4) Hospice benefits are available through the plan. Please consult the plan's Evidence of Coverage.